The Arts in Psychotherapy 52 (2017) 1–9

Contents lists available at ScienceDirect

The Arts in Psychotherapy

Research article

Development and pilot randomized control trial of a drama program to enhance well-being among older adults

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ARTICLE INFO

Article history:
Received 22 May 2016
Accepted 29 September 2016
Available online 30 September 2016

Keywords:
Successful aging
Drama instruction
Positive psychological traits
Randomized controlled trial
Community engagement

ABSTRACT

Objective: Develop a novel theatre-based program and test its feasibility, tolerability, and preliminary efficacy for improving empathy, compassion and well-being among older adults.
Method: Thirteen older adults were randomized to a 6-week Drama Workshop (DW) program or time-equivalent Backstage Pass (BP) control condition. Pre- and post-treatment measures included empathy, compassion, and mood scales. Additional post-treatment measures included self-rated change in empathy/compassion, confidence, and affect. Participants also rated their mood/affect after each session.
Results: The program was successfully completed and well-liked. No pre-to-post-treatment changes in empathy/compassion or mood symptoms were found in either group. Compared to BP, DW weekly ratings indicated higher levels of anxiety and lower happiness; however, the DW program had higher self-ratings of positive change in self-esteem, confidence, and happiness post-treatment.
Discussion: The DW was not shown to promote empathy/compassion. It was also reported as personally challenging. However, engagement in dramatic exercises and rehearsing and performing a dramatic piece was reported by participants as a positive growth experience, as indicated by the post-treatment ratings of enhanced self-esteem, confidence and happiness. Thus, such a program might be useful for counteracting some of the potential negative aspects of older age, including managing physical limitations and coping with losses.

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Introduction

The United States population is aging at a rapid rate due to advances in immunizations, medical care, and an increased focus on healthy living (e.g., better diet; decreased smoking rates) (Centers for Disease Control & Prevention, 2011; Ortman, Velkoff, & Hogan, 2014; van Meijgaard & Fielding, 2012). The U.S. Census Bureau estimates that by 2050, the number of individuals aged 65 and over will double from 43.1 million in 2012 to 83.7 million (Ortman et al., 2014). While living longer is associated with increased risk for debilitating diseases, such as dementia and cancer, current prevalence estimates predict the majority of the aging population will not experience such conditions (Hugo & Ganguli, 2014). Rather, the most frequent issues faced by individuals aged 65 and over are non-pathological age-related changes, including normal age-related declines in cognition, increasing physical limitations, and loss of partners and peers (Depp, Vahia, & Jeste, 2010). Facilitating the maintenance of good quality of life and factors that improve well-being in late life, despite these age-related changes, is imperative (Jeste & Palmer, 2013; Moore et al., 2015b; Polyakova et al., 2014; Steffens, Fisher, Langa, Potter, & Plassman, 2009).

In recent years, research has highlighted the positive impact of social support in the aging population (Holt-Lunstad, Smith,

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http://dx.doi.org/10.1016/j.aip.2016.09.007
0197-4556/Published by Elsevier Ltd.

Table 1
Demographic and Baseline Characteristics.

	Drama Workshop(n = 7)	Backstage Pass(n = 6)	t-value	Cohen's d
Age	78.0 (8.1)	75.2 (6.9)	0.68	0.41
Gender (% female)	71.4%	83.3%	0.47	0.28
Race/Ethnicity (% Caucasian)	85.7%	100%	–	
Education (years)	15.3 (3.1)	15.8 (1.6)	0.39	0.24
Employment Status				
% Retired	100%	66.7%	1.72	1.04
% Employed Part-Time	0%	33.3%		
Living Situation				
% Live Alone	28.6%	66.7%	1.11	0.67
% Live with 1+ Other Person(s)	71.4%	33.3%		
Primary Outcome Measures – Baseline				
TEQ	52.3 (2.9)	54.8 (4.6)	1.21	0.73
SCBCS	5.8 (1.3)	6.2 (0.8)	0.72	0.43
MET				
Cognitive Empathy	20.57 (0.98)	21.50 (1.38)	1.42	0.86
Affective Empathy	7.49 (1.30)	6.82 (1.66)	0.82	0.49
GDS	0.7 (1.1)	0.7 (1.6)	0.06	0.04
BAI	8.0 (6.9)	5.0 (6.1)	0.73	0.44

Note. $^{*}p < 0.05$; $^{**}p < 0.01$; Values are Mean (SD), unless otherwise noted. CES-D = Center for Epidemiologic Studies-Depression scale, Happiness subscale; TEQ = Toronto Empathy Questionnaire; SCBCS = Santa Clara Brief Compassion Scale; MET = Multifaceted Empathy Test; GDS = Geriatric Depression Scale; BAI = Beck Anxiety Inventory.

& Layton, 2010). Increased social support has been show to predict better cognitive performance (Seeman, Lusignolo, Albert, & Berkman, 2001), greater life satisfaction (Siedlecki, Salthouse, Oishi, & Jeswani, 2014), improved health-related quality of life (Centers for Disease Control & Prevention, 2009), and reduction in risk for age-related disabilities (Mendes de Leon, Gold, Glass, Kaplan, & George, 2001). A lack of social support is associated with increased loneliness, which is a known predictor of increased risk for morbidity and mortality (Perissinotto, Stijacic Cenzer, & Covinsky, 2012). Therefore, studies focused on increasing social connectedness among older adults are likely to have a positive impact on quality of life and well-being.

Empathy and compassion are constructs that have been identified as contributing to the development and maintenance of healthy interpersonal relationships (Crocker & Canevello, 2008; Lim, Condon, & DeSteno, 2015; Trobst, Collins, & Embree, 1994). Empathy can be defined as an individual's ability to feel with another or to put one's self in another's shoes (Reynolds & Scott, 1999; Zaki, Bolger, & Ochsner, 2008), whereas compassion can be conceptualized as a sympathetic concern of another's suffering together with an active desire to relieve that suffering; in other words, compassion is considered an outward behavioral expression of empathy (Halifax, 2012). While a growing body of literature has evaluated the neurobiological and demographic factors contributing to empathy and compassion in late life (Moore, Dev, Jeste, Dziobek, & Eyler, 2015; Moore et al., 2015c), no research has yet assessed whether these constructs can be directly modified among older adults. Our previous work identified a link between experiencing a negative life event within the past year and greater compassion in late life, which helped shape the goals of the present study (Moore et al., 2015c).

This study, termed the Empatheatre Project, examined the preliminary efficacy of a theatre-based program for altering levels of empathy, compassion and well-being in an older adult community sample by exercising the neural systems that are used to *put oneself in another's shoes* (Moore et al., 2015a; Singer & Lamm, 2009). Fundamentally, embodying a role as an actor involves temporarily adopting the physical and mental attributes of another in order to create a believable scenario for the observer. In correlational studies examining the relationship between empathy and acting, research has been mixed. In one study, group differences in empathy were found among actors compared to nonactors (Nettle, 2006), whereas another study found no differences between actors and nonactors on self-reported levels of empathy (Goldstein, Wu, & Winner, 2009). More recently, researchers have begun to examine the causal impact of acting on various outcomes. In one study, four-weeks of dramatic instruction was shown to significantly improve well-being and cognitive functioning (word reading and problem solving) among an older adult sample in comparison to individuals in a no-treatment control condition (Noice, Noice, & Staines, 2004). Another longitudinal study specifically evaluated the effectiveness of utilizing theatre-based programs in order to increase levels of empathy among elementary and high school students (Goldstein & Winner, 2012). Participants in this study received ten months of either acting or other arts training (music, visual arts) in an open-label, nonrandomized trial, and in both age groups participants in the acting group demonstrated post-treatment increases in empathy. In a small pilot Jaaniste, Linnell, Ollerton and Slewa-Younan (2015) found no differences in quality of life between a drama therapy group and a movie watching group. Despite such findings, as of yet, no studies have evaluated the effectiveness of acting training programs for increasing empathy and compassion among older adults. As a first-step in testing the hypothesis that drama instruction would increase empathy and compassion in late life, we developed a theatre-based program and tested the feasibility (i.e., is this program capable of being done?), tolerability (i.e., is this program acceptable to the participants?) and preliminary efficacy of this program among a community sample of older adults. The study was performed in three Phases: Phase I – Focus Group; Phase II – Open-Label, Nonrandomized Treatment Trial, in which the participants chose to either participate in a drama-instruction program (treatment condition) or a theatre-learning program (control condition); and Phase III – Pilot Randomized Controlled Trial (RCT) comparing the drama-instruction program to the theatre-learning program.

Method

Participants

Twenty-six older adults were enrolled across three separate phases of the study (described below). Participants were eligible to co-enroll in Phases I and II; however, participation in Phases I or II excluded participation in Phase III. Phase III participants (mean age = 77) were primarily female, reported an average of 15.6 years of education and 92% of the sample self-identified as Caucasian (see Table 1). We partnered with Jewish Family Service Aging and Wellness Program's College Avenue Center (hereafter